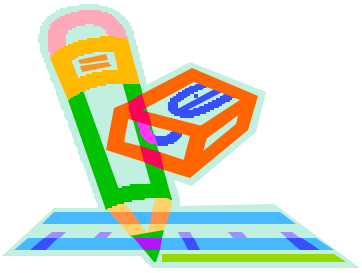
State of Vermont
Department of Health
The Division of Mental Health

Fee-For-Service Medicaid Reference Material For Mental Health Covered Services (Service Planning and Coordination and Community Supports) Under the State Medicaid Plan



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INTRODUCTION

At the request of the Designated Agencies (DAs), the Division of Mental Health (DMH) has developed the *Fee-For-Service Medicaid Reference Material:* for Mental Health Covered Services under the State Medicaid Plan. These materials may be used as supplemental training material along with the *Medicaid Fee-for-Service Procedures Manual.* Together with supervision, they should assist DA staff to provide clear and consistent documentation of mental health treatment and services funded by fee-for-service Medicaid.

Some of the specific reasons why the Individual Plan of Care and Summary of Services (Progress Notes) are beneficial and require clear documentation include the following:

1) Clients and providers agree what the treatment is trying to accomplish.
2) Notes track whether services and supports are meeting the client's needs.
3) Plans, notes, and billing records demonstrate that services have been delivered and documentation meets Medicaid standards for payment.
4) Clinicians have prompts to think analytically and critically about optimal therapeutic interventions for the client.

Outpatient and children's mental health services are designed to assist individuals who have psychological needs that result in diminished function. DAs provide clients these services to improve function and promote community connections.

The Division of Mental Health: (a) monitors the quality of services to ensure that beneficiaries receive quality care (documentation of good clinical practices) and (b) provides assurances to the state and federal government that Medicaid services documentation meets minimum standards. This reference material was designed to support DA staff in achieving basic documentation requirements in clinical files.

SECTION I

OVERVIEW OF THE MENTAL HEALTH MEDICAID BENEFITS PACKAGE

The Medicaid benefits package is broad and covers medically necessary mental health services. For the purposes of this manual, the DMH defines a medically necessary service as "an intervention prescribed by the treating psychiatrist to provide the most appropriate mental health treatment and support necessary to diagnose, treat, avert deterioration, and improve and maintain functioning of a person with a mental health condition." The definition's breadth reflects differing needs of a variety of individuals. The types of Medicaid interventions (Medicaid Modality) include Clinical Assessment, Service Planning and Coordination, Community Supports, Emergency, Individual/Family/Group Therapy, Medication Supports, and others. **This reference material will focus on Community Supports and on Service Planning and Coordination.**

The treatment process is multifaceted and shaped by clinical factors. Sometimes the client has co-occurring disorders along with other overlapping issues/treatment needs (*e.g.*, physical health, youth justice, employment, and education). Remember that to be eligible for Medicaid payment for mental health services, the State Medicaid Plan authorizes the plan of care only as "necessary to improve or ameliorate a mental health condition." Therefore, document the emotional or psychological factors that benefit these other needs. For example, mental health Medicaid does not pay for education, but it can pay for the mental health treatment and supports that enable the individual to participate in an educational process. If the agency is unable to document those emotional and psychological factors, then do not bill Medicaid for those services.

A. COMMUNITY SUPPORTS:

Individual and Group Community Supports are specific, individualized, and goal oriented services that assist individuals (and families) in developing skills and social supports necessary to promote positive growth. These supports may include support in accessing and effectively utilizing community services and activities, advocacy and collateral contacts to build and sustain healthy personal and family relationships, supportive counseling, and assistance in managing and coping with daily living issues. Community supports may be provided in a group setting; no more than four clients to one staff person may be present.

1. Individual Community Supports:

- *Accessing and Utilizing Community Services and Activities*:

Accessing and utilizing community services and activities may include the development of those skills that enable a person to seek out, clarify, and maintain resources, services, and supports for more independent living in the community, including communication and socialization skills and techniques.

- *Advocacy and Collateral Contacts:*

Advocacy (defends a cause) and collateral (serving to support or corroborate) contacts include "direct" supportive contacts with family or significant others and coordination with area resources and services to insure an effective treatment environment for the individual being served by the agency. E-mail is not an allowable mode of service. The Medicaid client must be central to such services.

- *Supportive Counseling:*

Supportive counseling services are directed toward: a) the elimination of psychosocial barriers that impede development, or b) the modification of skills necessary for independent functioning in the community. The emphasis is upon advice, opinion or instruction given to an individual to influence his / her judgment and or conduct in everyday situations. Supportive counseling can be provided either face-to-face or on the telephone, but not through e-mail.

- *Managing and Coping with Daily Living:*

Managing and coping with daily living issues may include support in acquiring functional living skills, resources, and guidance in areas such as budget, meal planning, household chores / maintenance, and community mobility skills. Documentation must emphasize that these types of services are provided as part of the treatment of a mental health disorder and how they are helping.

2. Group Community Supports:

A group is defined as a collection of people brought together by mutual interests, who are capable of consistent and uniform action. Group community supports use group techniques to help individuals:

- resolve symptoms
- increase function
- facilitate emotional and psychological amelioration of a mental disorder
- reduce psychosocial stress
- improve relationship problems
- improve their ability to deal with difficulties in the social environment

Group community supports may be an appropriate intervention and should be prescribed as such in the treatment plan. This intervention strategy should clearly align individuals' treatment goals, emphasizing interactions and mutuality of issues between two or more individuals for anticipated benefits. Documentation must specify how the goals, treatment, support, and outcomes of each individual participating in the group integrate with the group's goals and outcomes.

B. SERVICE PLANNING AND COORDINATION :

Service Planning and Coordination assists individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports for a specific individual. Services and supports that are planned and coordinated may be formal (provided by the human services system) or informal (available through the strengths and resources of the family or community). Services and supports include discharge planning, advocacy, monitoring the well-being of individuals (and their families), and supporting them to make and assess their own decisions.

1. Service Planning

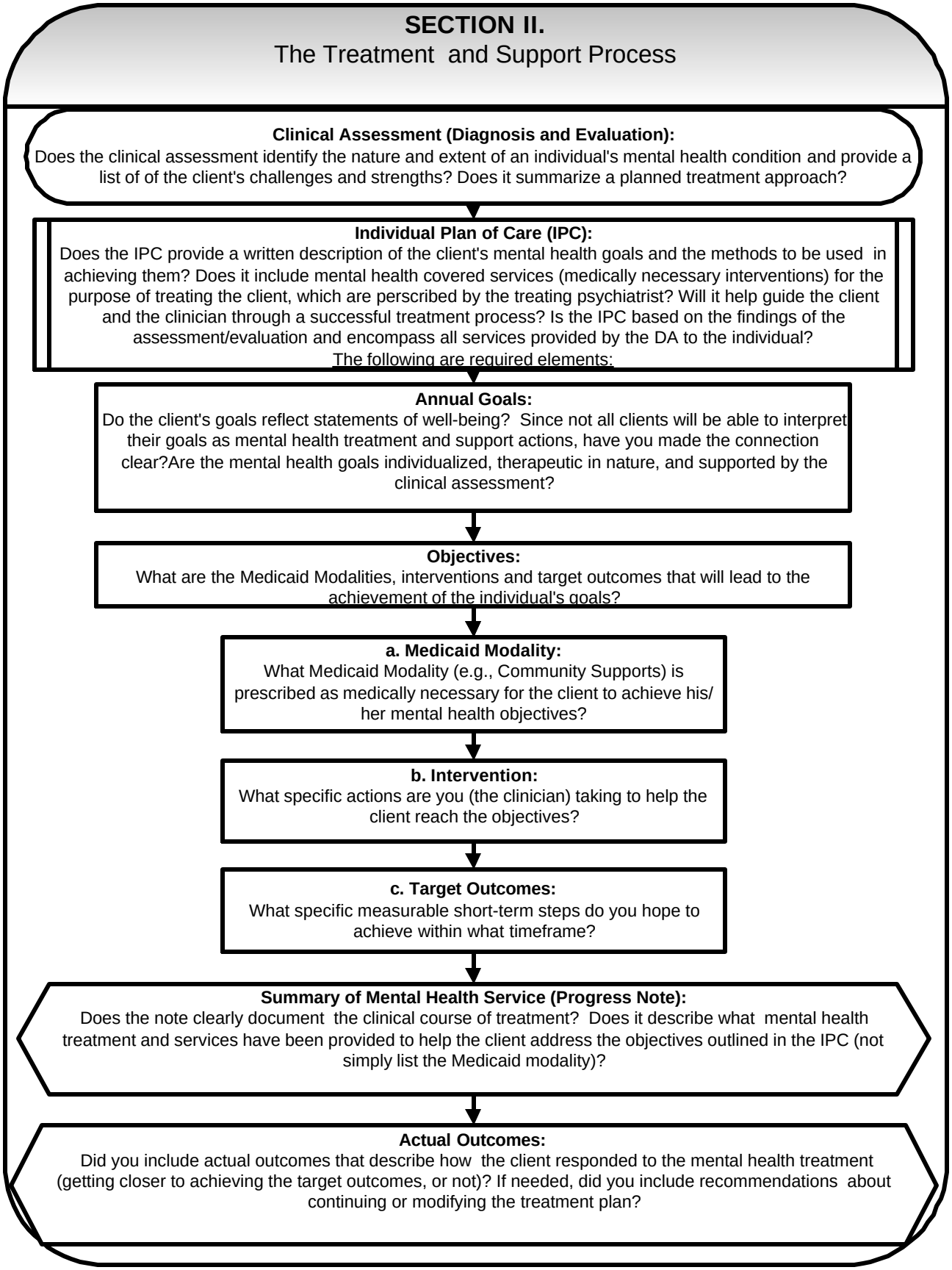
Service Planning consists of the following elements:

- staff conferences, with or without the presence of the individual
  [*Note*: to distinguish from Community Support collateral contact, Service Planning is usually done "indirectly" by contacting someone else (*e.g.*, family member) to discuss the client.]
- case discussions to design, review, or redesign individual plans of care
- monitoring to determine the appropriateness of on-going treatment

2. Service Coordination

Service Coordination involves contact with a formal service or informal support provider other than another DMH Medicaid funded fee-for-service provider for the purpose of case review or consultation regarding the provision and coordination of services to a specific individual. Service coordination includes both face-to-face and telephone consultation with other providers. Service professionals can include landlords, physicians, juvenile justice personnel, educators, child welfare workers from the Department for Children and Families, utility companies, employers, and others. Service coordination may also occur with family, guardians, or primary support relationships to promote continuity of services between the client's living and educational environments.

SECTION II.
The Treatment and Support Process



Examples

Clinical Assessment:

Strengths and Challenges: enthusiasm, sense of humor, loss of pleasurable activities, invalidating environment, and inability to control threatening behavior impedes attainment of his goals

Individual Plan of Care:

Client Goal:

1) I want more friends, and 2) I want to have more fun and deal with the outside world (ask, "Give me examples of what you mean by fun and what gets in the way of you achieving that goal?)

Mental Health Goal:

1) Individual will increase the number of positive statements of self, 2) Individual will broaden his understanding of friendship and the negative impacts of aggression

3) Individual will decrease isolation through structured socialization groups focusing on communication, and 4) Interactions with peers and friends will improve

Objectives:

1) Individual will learn to understand others' feelings and boundaries of mutual respect (cooperation, self-reflection, responding, initiating, and listening), 2) Individual will gain new interpersonal skills to establish positive peer relationships within his school setting, and 3) Individual will begin to identify triggers for anger and begin to articulate ways in which to avoid situations when unable to control anger

a. Medicaid Modality:

1) Service Planning and Coordination 1 hour every 2 weeks, 2) Individual Community Support 2 hours a week, and 3) Group Community Support 1 hour a month

b. Intervention:

1) Clinician will assist the individual to improve social skills,2) Clinician will support the individual to learn to understand other's feelings and boundaries of mutual respect (cooperation, self-reflection, responding, initiating, and listening), 3) Support worker will assist the individual to identify and begin to participate in community activities and associations that he will enjoy, 4) Clinician will assist the individual to list sources of stress and pressure that trigger aggressive behavior 5) learn anxiety scale to gauge level of anxiety and practice 2 anger management strategies, and 6) Clinician will help the individual to express his emotions and practice socialization skills and coping skills

c. Targeted Outcomes:

1) Individual will increase the number of positive statements from zero to two a week by DATE, 2) Decrease his aggressive behaviors toward his classmates from 4 a day to 1 by DATE, and 3) Individual will increase number of times he reports expressions of his feelings of being able to deal with his peers and "the outside world" by DATE

Summary of Service (Progress Note)

1) Individual continues to be successfully going out with his peers. He has begun to ask for assistance when social interactions become difficult. He recently asked his coach to mediate a discussion with a peer at swimming that he wanted to stop putting him down and treat him fairly. He did this entirely on his own initiative, 2) Case manager remains in close contact with the classroom teacher and the client's parents to facilitate consistency across settings and to provide supportive counseling, 3) Family visits continue by the community support worker to reinforce and practice coping skills learned in Group , 4) Community support worker visited individual at the school today for purposes of providing support around social isolation in math class. Encouraged him to say, "hi" to one new person a week in math class. Offered emotional support, and monitored follow-through with therapists' treatment suggestions regarding anger management strategies.

Actual Outcome:

1) Individual practiced (three times) effective communication skills he learned in group therapy, 2) Mother expressed improvements in her son's behaviors (list of those behaviors), 3) Twice this month he did seek feedback and attempted to utilize positive coping strategies to regulate emotions and navigate challenging situations. 4) Individual participated in three fun activities with his peers this month and expressed his feelings of anger and frustration. 5) No incidents of anger outburst reported this month 6) His ability to greet people in a socially acceptable manner is improving greatly, 7) Math teacher reported no improvements in social interactions with his peers this month.

A. CLINICAL ASSESSMENT (DIAGNOSIS AND EVALUATION)

The Clinical Assessment (Diagnosis and Evaluation) gathers data needed to formulate clinical impressions to be used as the basis for the diagnosis and the treatment process. All clients should receive a clinical assessment prior to the development of a treatment plan.

B. INDIVIDUAL PLAN OF CARE

The Individual Plan of Care (IPC) is directly related to the clinical assessment's findings and recommendations and must include a prescription by the attending psychiatrist for all services intended to be provided by the center to the individual. * The IPC is developed to guide the client and the clinician through the mental health treatment process. The client / guardian should be directly involved in establishing his / her IPC to the extent possible. It is not required that the individual be present when the IPC is updated.

Checklists by themselves do not constitute an Individual Plan of Care. Additional narrative is required to explain the information that has been "checked off."

Both the plan and the quarterly reviews must be signed by the primary clinician or case manager, the prescribing physician, and, whenever possible, by the client. The IPC is a working document that must be developed annually (total rewrite) and reviewed quarterly unless the individual's condition and / or treatment needs change, necessitating the addition, deletion, or modification of prescribed interventions. The IPC must contain the following components:

1. Mental Health Annual Goals:

The individual's mental health annual goals are statements of the mutually desired overall, short or long-range results of the mental health treatment and supports. The client's goals should appear prominently in the treatment plan and be stated in positive terms reflective of the individual's personal desires. The clinical formulation for the individual's goals should always be evident. If the client's wording of a goal is not a mental health goal, then it is incumbent on the clinician to reframe the goal to reflect the mental health problem / issue. Goals should:

- be individualized
- be supported by information in the clinical assessment
- identify desired clinical results (*e.g.*, increase his / her ability to cope) to be achieved by mental health treatment, or state resolution of the identified issues. An expected timeframe may accompany a goal or be included with identified objectives of the goal.
- be achievable. Goals that have not been met at least annually or as appropriate should be altered so that they can be met or deleted with an explanation given at the time of the IPC update or in the progress note.
- be useful. Select a reasonable number of goals that are realistically achievable, not condensed into one overwhelming goal.

***** A prescription can also be authorized by an advanced practice registered nurse who has been authorized by the Division of Mental Health

2. Objectives:

Objectives are observable and measurable short-term steps, which, when completed, will lead to the achievement of the mental health goals. Objectives should state the Medicaid modality and interventions that will result in the achievement of the annual overall goal. Often, Medicaid modality and interventions are described concurrently. Objectives should contain the following 3 elements: a) Medicaid modality, b) interventions, and c) target outcomes. They should be explained in terms that are understandable to the client and provide a clear description of the anticipated treatment goal outcome and the expectation of the client. An expected date of achievement should be identified for each objective.

a. Medicaid Modality:

Medicaid modalities are services defined in the State's Medicaid plan. They are prescribed by the authorizing psychiatrist as medically necessary for the health of the client. Because these services are medically prescribed, it is ***mandatory*** to include the name of Medicaid modality, the frequency with which it is prescribed, and the signature of the psychiatrist (*e.g.* Community Supports, 2-4 hours per week).

b. Interventions:

Interventions describe the mental health strategy the clinician uses to treat the specific factor identified as the problem. These are ***actions of the clinician*** designed to help the client complete the objectives. There should be at least one treatment or support activity for each objective. Success needs to be monitored and changed accordingly. If the client does not accomplish the objective as planned, perhaps a new or different treatment or support should be considered for the plan. Interventions must be individualized and measurable.

c. Target Outcomes

Target Outcome is a result of a process, either positive (desired) or negative (not desired). The clinician or treatment team must establish target outcomes to indicate the expectation of improvement at the completion of the client's treatments and supports (*i.e.*, the clinical care process). The clinician is expected to monitor the client's IPC target outcomes.

C. SUMMARY OF MENTAL HEALTH SERVICE (also known as the progress note)

The purpose of the Summary of Mental Health Service for Community Support and for Service Planning and Coordination is to document the clinical course of treatment. The notes are intended to guide the course of the prescribed treatment and to provide a chronological listing of the clinician's interventions and the client's activity and progress. The notes should relate to assessment, address the goals and objectives outlined in the treatment plan, build upon information from previous progress notes, and identify either overall outcomes or progress. The Summary of Service note must describe the clinician's actions and the client's response to show that a mental health treatment intervention occurred and had an effect on the client's condition (or not). The client must be the primary target for the intervention.

1. Actual Outcomes:

In order to achieve optimal client care, the clinician is expected to compare the client's actual outcomes to the IPC target outcomes for results. This analysis is important to determine if the treatment and support are meeting expectations. The Summary of Service should describe the positive or negative results of the treatment and support and the relevance to the client's clinical needs (*i.e.*, efficacy and appropriateness).

2. Documentation

- Service Planning and Coordination and Community Supports may be documented by each unit of service, or with one monthly summary note. Each program, or subcomponent, must designate which method of documentation it will use.
- If both individual community support and group community support are provided in a month, each service modality needs its own separate note or subsection in the monthly note.
- Each summary of a mental health service note should include:
    - the client's condition upon his / her arrival
    - an assessment of observations / perspective of progress toward goals
    - client's reaction to treatment activities conducted by the clinician
    - future plans for the client
    - each / all mental health services by describing the discussion, skill building provided, its purpose, how it relates to specific treatment objectives, and the client's response
- Changes related to physical health or significant life problems should be noted.
- When a new plan is developed, there should be a statement of specific issues indicating why services have changed.
- The clinician who writes the note should sign the summary of service note. No one else is required to sign the progress notes. Qualifications, degrees, and titles of all staff must be on file at the agency.

SECTION III

RECORD KEEPING REQUIREMENTS

A. GENERAL COMMENTS

- Documentation of services provided must be legible, of sufficient clarity, and specific enough to insure eligibility for payment. The audit team must be able to read the service documentation.
- Keep evaluations and treatment plans together in a clearly identified part of the record.
- File updates with originals in chronological order.
- Do not remove evaluations, or treatment plans, including updates from records.
- The use of whiteouts in the clinical record is prohibited. A single line is the only acceptable method of changing information. Information to be altered should have a single line through the information and must be accompanied by the initials of the staff making the alteration.
- Each reimbursed service must be documented in the individual's case record. This documentation may be in another provider's files but must be available to Title XIX auditors and identified with the individual's name and / or record number.
- If an individual has had no services for six months or the IPC indicates that the case should be closed, then it must be considered closed.
- Individuals requesting services after six months from the date of their last service must have a new plan created.